STATE OF MICHIGAN

COURT OF APPEALS

MIC GENERAL INSURANCE CORPORATION,

Plaintiff-Appellant,

v

HEALTHPLUS OF MICHIGAN, INC.,

Defendant-Appellee.

UNPUBLISHED

No. 196207
Genesee Circuit Court
LC No. 95-37810-CZ

Before: Markman, P.J., and McDonald and Fitzgerald, JJ.

MARKMAN, J. (concurring).

I concur with the majority that this case should be reversed and remanded. However, I would do so exclusively in order to determine whether a referral to the Craig Institute or any other rehabilitation facility was ever sought by the Fullers. If such a request for referral was made, then I believe that the medical reasonableness of defendant's denial of the referral under the Group Services Contract must be determined.[1] It is implicit in the HMO contract that decisions to refer or to not refer must be reasonably grounded lest the health insurer routinely be able to shift costs to the no-fault insuror where personal protection benefits have been coordinated with other health and accident coverage. *Federal Kemper Ins Co, Inc v Health Ins Administration, Inc*, 424 Mich 537, 546; 383 NW2d 590 (1986); *Michigan Mutual Ins Co v American Community*, 165 Mich App 269, 274-275; 418 NW2d 455 (1987). Such an inquiry into the medical reasonableness of a referral decision would include an evaluation of Judy Fuller's injuries as well as the respective medical resources available to her inside and outside of the HMO.

However, if a request for referral was not made by the Fullers pursuant to the HMO contract, then this is the end of the trial court's inquiry, in my judgment, and it must grant summary disposition in favor of defendant.[2] It is well-understood that a party entering into a contract for medical services with an HMO thereby sacrifices some measure of their freedom with regard to their choice of provider. While they remain free to obtain the services of any provider they choose, they are entitled to reimbursement from the HMO only to the extent that such provider is either within the purview of the HMO or else is a non-affiliated provider who has been specifically authorized by the HMO pursuant to its own procedures. To the extent that *Westfield Co v Grand Valley Health Plan*, 224 Mich App

385; 568 NW2d 854 (1997) supports the proposition that HMO contract provisions need not be construed in the same manner as other contract provisions because to do so would potentially be to place "form over substance," I respectfully reject this holding and abide by it only under the requirements of MCR 7.215(H). Further, I would retain jurisdiction.

/s/ Stephen J. Markman

[1] This would also encompass an assessment of the reasonableness of defendant's conduct either in failing to act upon a proper referral request or in failing to comply with its own procedures established in connection with referral requests.

[2] An exception might obtain if there were emergency medical care provisions in the HMO contract that arguably applied to the instant circumstances. I am not aware, however, of any such provisions having been invoked by plaintiff or by the Fullers.